intended to be proposed to H.R. 1735, an act to authorize appropriations for fiscal year 2016 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1798

At the request of Mrs. BOXER, the names of the Senator from Michigan (Ms. STABENOW) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of amendment No. 1798 intended to be proposed to H.R. 1735, an act to authorize appropriations for fiscal year 2016 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1799

At the request of Mrs. BOXER, the name of the Senator from Montana (Mr. TESTER) was added as a cosponsor of amendment No. 1799 intended to be proposed to H.R. 1735, an act to authorize appropriations for fiscal year 2016 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1811

At the request of Mr. HATCH, the name of the Senator from Oklahoma (Mr. LANKFORD) was added as a cosponsor of amendment No. 1811 intended to be proposed to H.R. 1735, an act to authorize appropriations for fiscal year 2016 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

AMENDMENT NO. 1855

At the request of Mr. DURBIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of amendment No. 1855 intended to be proposed to H.R. 1735, an act to authorize appropriations for fiscal year 2016 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself, Mr. WHITEHOUSE, Mr. BLUMENTHAL, Mr. MURPHY, Mr. REED, and Mrs. BOXER):

S. 1529. A bill to promote the tracing of firearms used in crimes, and for other purposes; to the Committee on the Judiciary.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1529

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Crime Gun Tracing Act of 2015''.

SEC. 2. DEFINITION.

Section 1709 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd–8) is amended by—

(1) redesignating paragraphs (1) through (4) as paragraphs (2) through (5), respectively; and

(2) inserting before paragraph (2), as redesignated, the following:

''(1) 'Bureau' means the Bureau of Alcohol, Tobacco, Firearms, and Explosives.''.

SEC. 3. INCENTIVES FOR TRACING FIREARMS USED IN CRIMES.

Section 1701 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd) is amended by striking subsection (c) and inserting the following:

''(c) PREFERENTIAL CONSIDERATION OF APPLICATIONS FOR CERTAIN GRANTS.—In awarding grants under this part, the Attorney General, where feasible—

''(1) may give preferential consideration to an application for hiring and rehiring additional career law enforcement officers that involves a non-Federal contribution exceeding the 25-percent minimum under subsection (g); and

''(2) shall give preferential consideration to an application submitted by an applicant that has reported all firearms recovered during the previous 12 months by the applicant at a crime scene or during the course of a criminal investigation to the Bureau for the purpose of tracing, or to a State agency that reports such firearms to the Bureau for the purpose of tracing.''.

SEC. 4. REPORTING OF FIREARM TRACING BY APPLICANTS FOR COMMUNITY ORIENTED POLICING SERVICES GRANTS.

Section 1702(c) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd–1(c)) is amended—

(1) in paragraph (10), by striking ''and'' at the end;

(2) in paragraph (11), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(12) specify—

''(A) whether the applicant recovered any firearms at a crime scene or during the course of a criminal investigation during the 12 months before the submission of the application;

''(B) the number of firearms described in subparagraph (A);

''(C) the number of firearms described in subparagraph (A) that were reported to the Bureau for tracing, or to a State agency that reports such firearms to the Bureau for tracing; and

''(D) the reason why any firearms described under subparagraph (A) were not reported to the Bureau for tracing, or to a State agency that reports such firearms to the Bureau for tracing.''.

By Mr. CASSIDY (for himself, Mr. MCCONNELL, Mr. CORNYN, Ms. COLLINS, Mr. INHOFE, Mr. COATS, Mr. ROUNDS, Mr. VITTER, Mrs. CAPITO, and Mr. WICKER):

S. 1531. A bill to reform the provision of health insurance coverage by promoting health savings accounts, State-based alternatives to coverage under the Affordable Care Act, and price transparency, in order to promote a more market-based health care system, and for other purposes; to the Committee on Finance.

Mr. CASSIDY. Mr. President, the Supreme Court is about to rule on King v. Burwell. This decision is a question of a plain reading of the law, which is that subsidies shall only be given to those who reside in States which have established State exchanges. That is the plain reading of the law. The administration maintains that, no, ''States'' doesn't mean ''States,'' but, rather, it can be an exchange set up either by the State or the Federal Government.

Presuming the Supreme Court decides that a plain reading of the law is correct—that for a resident of a State to receive a subsidy, they have to reside in a State that has established an exchange—there are 37 States in which those currently receiving subsidies will lose their subsidies. This is important because under ObamaCare we have seen a dramatic increase in the cost of health insurance premiums. So many people who formerly would have been able to afford an insurance premium no longer can without the subsidy. What this means for that person in a State such as Louisiana is there will be someone in the middle of chemotherapy who can no longer afford their insurance without a subsidy. The insurance has been made so high because of ObamaCare that that patient is no longer able to afford her insurance and she is at risk of losing her coverage because the administration illegally implemented the law.

This is where we are going into the Supreme Court decision. Let me kind of now start on a different tack.

The President's health care law, ObamaCare, the Affordable Care Act, has continued to be singularly unpopular. A recent ABC poll showed that only 39 percent of Americans approved of the law. That is an alltime low—10 percent lower than it has been.

One can ask why it would be unpopular and why it would be particularly unpopular now. I think the reason it is unpopular in general is that ObamaCare is a coercive Federal Government program, that if you don't bend your will to the Federal Government, the Federal Government will penalize you. That is not how Americans view their relationship to the Federal Government. We don't expect the government to tell us what to do. There might be income taxes, which we pay, and there will be drafts in times of war, such as World War II, but in general, aside from those two things, the Federal Government should just stay out of our lives. In this case—ObamaCare—the Federal Government gets right in the middle of that which is most personal, and that is our health care.

I think the reason ObamaCare is particularly unpopular now is because of the premium increases that have resulted because of ObamaCare. Here are

some headlines: CNN, ''Obamacare sticker shock: Big rate hikes proposed for 2016''; AP, ''Many health insurers go big with initial 2016 rate requests''; AP again, ''8 Minnesota Health Plans Propose Big Premium Hikes for 2016''; the New York Times, ''In Vermont, Frustrations Mount Over Affordable Care Act''; and the Washington Post, ''Almost half of Obamacare exchanges face financial struggles in the future.''

In my own State, insurers are asking for 20 percent increases, and this is on top of premium increases that have resulted from the previous few years.

Indeed, the President likes to speak about how health care costs under ObamaCare have mitigated—health care costs. Actually, that began in 2007 before ObamaCare passed. But since ObamaCare passed, it has been true. Health care costs have not risen as they did in the past. Health insurance costs have gone up dramatically. The remarkable story of ObamaCare is that there is now no relationship between health insurance cost and health care cost. The insurance companies, with the regulations imposed by ObamaCare, are charging far more for insurance than one would expect because of the health care costs. Of course, the President chooses to speak of the cost of care, not the cost of premiums, but for the average person, it is the cost of premiums which is making her so frustrated with this law.

That brings us back to King v. Burwell. At this point, I am offering today, along with several original cosponsors, what we call the Patient Freedom Act. We give patients the power which ObamaCare took from them, and we give them the power by lowering the cost. We lower the cost by eliminating the mandates that are part of ObamaCare. We return power over insurance to the States, with the rationale that she who governs best governs closest to those who are governed. The insurance commissioner in that State should be able to decide what the person in their State wishes to have for their policy, not a Washington bureaucrat. And we give patients knowledge. We give them price transparency. They should know the cost of something that is ordered for them before they have the procedure performed as opposed to learning afterward. We give them portability, and we give them protection against preexisting conditions.

I and others—I think the Presiding Officer as well—have campaigned for several cycles that we were going to repeal and replace ObamaCare. In this situation, the Supreme Court will repeal a portion of ObamaCare—not all but a portion—in 37 States, and this is the plan that will replace that portion of ObamaCare which is repealed.

We like to look at it this way. We begin to plant the seeds. Now, in those 37 States, those 8 million people affected by the Obama administration's illegal implementation of the subsidy law—we make it better for them. We plant the seeds so that over time other aspects and eventually the entirety of ObamaCare will be replaced with something which gives the patient the power as opposed to a Washington bureaucrat.

Let me lay out what we do. King v. Burwell goes against the administration. The Supreme Court rules that the law has been implemented illegally. States will then have a choice: They can either establish a State exchange if they wish for the status quo of ObamaCare, the State can do nothing, which means in that State all of ObamaCare goes away for the private insurance market, or they can choose the Patient Freedom Act, which is the market-based reform that we think gives the patient the power and not the bureaucrat.

Now let me compare the two. I mentioned how under the Patient Freedom Act costs are lowered by repealing mandates. For example, under ObamaCare there is an individual mandate with a coercive penalty. The Patient Freedom Act does not have one. There is an employer mandate penalty. Yes, under ObamaCare the employer is penalized; under the Patient Freedom Act, no. There is the Federal essential health benefits mandate. Under ObamaCare, a Washington bureaucrat tells somebody that which they must purchase. In the Patient Freedom Act, we return that to the State insurance commissioner. We do not have these mandates. I can go on down the list, but the reality is that ObamaCare, coercive mandates; the Patient Freedom Act, no.

The money we make available to the States we take from the tax credits that ObamaCare would give to those in the State—those who are eligible and signed up—we take the Medicaid funding that would be available in the State for Medicaid expansion, and we combine those two for the total allocation that will go to that State.

Now, some would say: Wait a second. The Federal Government should not be in the business of helping people with health insurance. I say the Federal Government is deeply in that business already. If you look under public insurance, there is Medicare, Medicaid, CHIP, VA, TRICARE, and on and on where the Federal Government is providing health care benefits for a substantial portion—over 25 percent—of Americans. These are those Americans who get their insurance through the employer-sponsored insurance, where the employer and the employee can contribute to their insurance but they get a tax break on the purchase. That tax break averages about $1,700. We are speaking about that remaining group who purchases their insurance for themselves. We lower their cost by equalizing the tax treatment between the two. It is the same sort of tax break that those with the employer-sponsored insurance receive. We will now offer that same tax break to these folks and in so doing achieve that conservative goal of equalizing the tax treatment of those purchasing employer-sponsored insurance as opposed to purchasing on their own.

The funding goes to the patient. I am a doctor. I have been working in a public hospital system for 25 years. I learned working as a physician in both the private setting but also principally in the public hospital setting that whoever controls the dollar has the power. That makes no sense whatsoever. It is one of the major flaws in ObamaCare. Since these subsidies are based upon estimated earnings that are later reconciled through tax returns, Americans are facing onerous tax liabilities and penalties as a consequence.

Let me explain further how this wage-lock occurs, because increasingly Americans are going to be running into this problem. Let me give you an example. Last year, the least expensive premium for a silver plan to cover a 50-year-old individual in Aroostook County, ME, cost $6,300 through an Affordable Care Act exchange. But that, obviously, is not what most individuals pay. Instead, they receive a subsidy that phases out based on their estimated income. But again, the subsidy completely disappears at a sharp cliff at 400 percent of the Federal poverty level.

An individual whose estimated income is just less than this cliff, say, one that is earning $46,500, will pay 9.5 percent of his or her income, or $4,370, for insurance and the rest is covered by the Federal tax credits. But if it turns out that this individual actually made a bit more than 400 percent of the Federal poverty level—let's say the individual made $47,000—then, he or she would be on the hook for the entire $6,300 premium. In other words, a 50-year-old who makes just $500 more than he or she estimated will have to pay $2,000 more at tax time for health insurance in the exchange.

Think about what this means for a self-employed individual whose income fluctuates not only from year to year but from month to month. This is a financial nightmare to try to figure out.

This cliff does not just affect individuals who get their coverage through the ACA. Cliffs appear over and over in the design of the subsidies under ObamaCare, and couples and families will face them at different levels of income as their household size changes. What will these bait-and-switch health insurance premiums do to incentives to work harder, to earn more, to accept promotions? If you accept a promotion at work and then your income goes over that magic 400 percent of poverty threshold, you are going to lose your entire subsidy. You might well decide to turn down that raise at work or that opportunity to be promoted to a better job. What kind of system has been designed to discourage people from moving ahead in the workplace?

In the State of Maine, so far we have learned that at least 1,000 Maine families have lost their subsidies completely because they were in that situation where their income went over that threshold. Another 1,000 Mainers are finding out that they are losing part of their subsidy and are going to be on the hook for paying more money.

I will say to my colleagues that you are going to start hearing this in your States, and it particularly is going to affect people who are self-employed and who have to estimate what their income is going to be. Through no fault of their own—unless they are going to turn down work—they may well go over the threshold amount and lose their subsidy altogether. Remember, it takes just $1 in additional earnings at the 400 percent of poverty level to lose your subsidy altogether.

Let me give you an example of a Maine couple who contacted my office. They discovered to their horror that when they filed their taxes, they had earned more than the threshold and they owed $13,000 to the IRS for the health insurance they received through the ObamaCare exchange, on top of the $4,000 that they had been told their exchange coverage would cost.

Imagine finding out that because you worked a little harder, because you earned a bit more money, you now unexpectedly owe an extra $13,000 to the IRS because you lost your subsidy. The Patient Freedom Act would put an end to the bait-and-switch premiums that are built into the ObamaCare exchanges.

One of the reasons I opposed the Affordable Care Act was that there was nothing affordable about it. I predicted at the time that it would lead to fewer choices and higher insurance costs for many middle-income Americans and small businesses.

A ruling in favor of the plaintiffs in King v. Burwell would prompt Congress to protect those who would lose their subsidies, but it would also provide the opportunity to give States the option to replace the Affordable Care Act's poorly crafted mandates with patient-directed reforms that contain costs, provide more choices, and still provide assistance to those who need it most.

The Patient Freedom Act does exactly that. I urge my colleagues to support it.

Now, if it is a bureaucrat who controls that dollar, then the bureaucrat will dictate the type of facility the patient is seen in. If the patient controls the dollar, the hospitals are going to compete for her business, and she dictates the type of facility in which she is seen. So in the Patient Freedom Act, the money goes directly to the patient. It can go through the State. The money can be granted to the State on a per-patient enrolled grant type; and in so doing, the State would then distribute—and there are advantages for the State to do the distribution—or, if the State does not want that responsibility, it can be a Federal tax credit that goes into a health savings account that the patient controls. But either way, the patient controls the dollar. The patient has the power, not a bureaucrat.

Here is a brief example of how it will work: Here is the health savings deposit that goes into a health savings account. There will be some reforms in the bill that allow the patient to either use it as her contribution—as the employee's contribution on a employer-sponsored plan. She can directly contract with a provider network. She can purchase commercial insurance or, if she does nothing, the State has the option of creating a system, where someone is enrolled unless they choose not to be.

Again, I am going to call upon my experience as a physician. Think of a person who might be schizophrenic, homeless, living beneath a bridge. He is never going to do what ObamaCare mandates, which is to get on the Internet and fill out a 16-page form. It is just not going to happen. I have been there, I have done that. I have been in the ER in the middle of the night when a patient has come in with some acute medical or trauma condition. Under this system, though, the State could have this person enrolled unless they choose not to be.

So with the health savings account, they would have first-dollar coverage for a visit should they decide to go into an outpatient clinic for a foot that was infected. If they have some major issue and they are brought to the hospital, the catastrophic policy would then give them the coverage for that hospitalization but also protect the hospital, the doctors, and other providers from taking a total loss—which, by the way, society ends up paying for—because they have no coverage for that hospitalization. So with this system, we can achieve higher enrollments than are achieved under ObamaCare.

Last, let me talk about one more way in which we think patients will have the power. One, they will have power portability. Every year, in an open enrollment season, if the patient wishes to change plans, she may, without penalty. Secondly, she will be protected against preexisting conditions. The only rating that will be required for premiums will be for geography and age. A 57-year-old will get a bigger credit than a 20-year-old. But aside from age and, again, geographic—because it is more expensive to receive care in Manhattan, NY, than Manhattan, KS—that will be the only differences allowed. Lastly, there will be the power of price transparency.

Currently, a woman goes in with her daughter, the doctor orders a CT scan, and the patient has no clue what the cost of that CT scan is. Now, it can be anywhere from $250 to $2,500 or more. I pick those numbers because the LA Times had an article a couple years ago, they found that the difference in cash price for CT scans was $250 to $2,500. The only way someone could know is if they were an investigative reporter and able to find out, not if you are a mom with a sick child who needed a CT scan. For me, it is going to be great when the mother can take her smart phone, scan a QR code, and pull up something which says: CT scan $250 here, $2,500 there. I am going to make my decision based on some combination of cost, quality, and convenience. I will pick based upon my values on where to go. It is not a Washington bureaucrat, it is a mother who is going to make that decision.

Again, continuous coverage protects those with preexisting conditions, and we mentioned the price transparency. In this way, Republicans will give States the option to choose. Again, they can stay in ObamaCare if they want. They have that option now. They can do nothing, and it goes away if the Supreme Court rules that the subsidies have been implemented illegally or they can go with the Patient Freedom Act—the Patient Freedom Act—which gives patients the power by lowering costs, lowering the cost by eliminating mandates, returning power over insurance back to the commissioners who govern closest to those who actually will be using the insurance, and then giving the patient the power of portability, protection against preexisting conditions, and the power of price transparency.

Ms. COLLINS. Mr. President, let me begin my remarks this evening by commending my friend and colleague the Senator from Louisiana for coming up with a creative and comprehensive health care bill that I am pleased to cosponsor.

As a physician, Senator CASSIDY knows far better than most of us in this body what it is like to deliver health care and has made a real effort to come up with a public policy response in anticipation of the Supreme Court's decision in King v. Burwell, which is expected to be handed down later this month. So I thank him for his work and his creativity in tackling a very complex issue.

As I mentioned, later this month, the Court is expected to rule in King v. Burwell, a case challenging the availability of premium tax credits under the Affordable Care Act in the 37 States that have not established a State-run health insurance exchange.

If the Supreme Court rules in favor of the plaintiffs, as many experts expect it will, 6.4 million Americans who are now receiving premium tax credits through the federally run exchanges will lose their subsidies, and, as a result, their health insurance may well become unaffordable. This includes almost 61,000 people in my State of Maine.

Such a decision will place responsibility on Congress and the President to work together to protect those individuals. Senator CASSIDY and I believe we can do this by extending the current subsidies for a transition period, as contemplated by the sense-of-Congress

language included in the Patient Freedom Act that we are introducing today.

But the Supreme Court's decision will also invite us to think anew about how to ensure that all Americans have access to affordable, high-quality health care. We can advance this goal by revamping and reforming the Affordable Care Act to improve the quality and affordability of health care while retaining the insurance market reforms that are so important to consumers.

Senator CASSIDY's Patient Freedom Act is precisely the type of new thinking we need. As the title of this bill suggests, the Patient Freedom Act is built on the premise that freeing people to take charge of their health care is superior to the one-size-fits-all approach of ObamaCare. A decision for the plaintiffs in King v. Burwell would essentially leave States with two options, absent congressional action. They could either set up a State-run exchange to ensure that their residents have access to the Affordable Care Act subsidies or do nothing and allow their residents to lose these ObamaCare subsidies. Under Senator CASSIDY's bill, however, States with federally run exchanges would have a third option. They would have the choice of participating in the new Patient Freedom Act.

Participating in the Patient Freedom Act would allow States to structure their health insurance market without an individual mandate or an employer mandate or many of the other expensive mandates under ObamaCare. In return, States would have to offer their citizens a basic health insurance plan that would include first-dollar coverage through a health savings account, basic prescription drug coverage, a high-deductible health plan to protect enrollees against medical bankruptcy, coverage for preexisting conditions—a good provision of the current law that we would retain—coverage through a parent's plan for children up to age 26—another good provision of the law that we would retain—and there could be no annual or lifetime limits on insurance claims, again a good provision of the current law that we would retain.

Here is how it would work: The Federal Government would provide funding directly into the health savings accounts of individuals insured through the Patient Freedom Act. These funds would be phased out for higher income individuals. The aggregate funding for these per-patient, per-capita grants would be determined based on the total amount of funding that the Federal Government would have provided in the form of ObamaCare subsidies in each State, plus any funding each State would have received had they chosen to expand their Medicaid Program, even if, like the State of Maine, they had chosen not to do so.

In addition to Federal funds, individuals and employers could make tax-advantaged contributions to these health savings accounts. The bill even provides for a partial tax credit for very low-income individuals who do receive employer-based coverage, but it would help these workers pay for their deductibles and copays.

Individuals who are insured under the Patient Freedom Act would receive debit cards tied to their health savings accounts, which they could use to purchase a high-deductible health plan to pay directly for medical expenses or pay premiums for a more generous health insurance policy. In addition, health care providers receiving payment from the health savings accounts would be required to publish cash prices for their services, which would add transparency that we desperately need to move toward a more patient-directed health care future.

The promise of patient-directed health care is one of the advantages of this approach, but it has other advantages as well. For example, residents of States that elect this option would no longer face the individual mandate penalty that can cost individuals 2.5 percent of their income and the typical American family of four an estimated $2,100 next year. It would also codify the elimination of the employer mandate in these States, freeing these employers to add jobs and let their full-time employees work 40 hours a week. ObamaCare has been causing some employers to reduce hours for their employees. The result has been smaller paychecks for those workers.

Perhaps most important, however, the Patient Freedom Act would do away with what the superintendent of insurance in Maine refers to as ''wage lock.'' That is caused by the fact that the subsidies in the ObamaCare exchanges phase out completely at 400 percent of the Federal poverty level. In other words, there is a cliff there. Now, 400 percent of the poverty level is about $47,000 for an individual and $64,000 for a couple. Taxpayers who earn just $1 more than the threshold lose their entire subsidy.

By Mr. CORNYN:

S. 1534. A bill to require the Secretary of Veterans Affairs to ensure that the medical center of the Department of Veterans Affairs located in Harlingen, Texas, includes a full-service inpatient health care facility, to redesignate such medical center, and for other purposes; to the Committee on Veterans' Affairs.

Mr. CORNYN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1534

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Treto Garza South Texas Veterans Inpatient Care Act of 2015''.

SEC. 2. DESIGNATION OF MEDICAL CENTER OF DEPARTMENT OF VETERANS AFFAIRS IN HARLINGEN, TEXAS, AND INCLUSION OF INPATIENT HEALTH CARE FACILITY AT SUCH MEDICAL CENTER.

(a) FINDINGS.—Congress makes the following findings:

(1) The current and future health care needs of veterans residing in South Texas are not being fully met by the Department of Veterans Affairs.

(2) According to recent census data, more than 108,000 veterans reside in South Texas.

(3) Travel times for veterans from the Valley Coastal Bend area from their homes to the nearest hospital of the Department for acute inpatient health care can exceed six hours.

(4) Even with the significant travel times, veterans from South Texas demonstrate a high demand for health care services from the Department.

(5) Ongoing overseas deployments of members of the Armed Forces from Texas, including members of the Armed Forces on active duty, members of the Texas National Guard, and members of the other reserve components of the Armed Forces, will continue to increase demand for medical services provided by the Department in South Texas.

(6) The Department employs an annual Strategic Capital Investment Planning process to ''enable the VA to continually adapt to changes in demographics, medical and information technology, and health care delivery'', which results in the development of a multi-year investment plan that determines where gaps in services exist or are projected and develops an appropriate solution to meet those gaps.

(7) According to the Department, final approval of the Strategic Capital Investment Planning priority list serves as the ''building block'' of the annual budget request for the Department.

(8) Arturo ''Treto'' Garza, a veteran who served in the Marine Corps, rose to the rank of Sergeant, and served two tours in the Vietnam War, passed away on October 3, 2012.

(9) Treto Garza, who was also a former co-chairman of the Veterans Alliance of the Rio Grande Valley, tirelessly fought to improve health care services for veterans in the Rio Grande Valley, with his efforts successfully leading to the creation of the medical center of the Department located in Harlingen, Texas.

(b) REDESIGNATION OF MEDICAL CENTER IN HARLINGEN, TEXAS.—

(1) IN GENERAL.—The medical center of the Department of Veterans Affairs located in Harlingen, Texas, shall after the date of the enactment of this Act be known and designated as the ''Treto Garza South Texas Department of Veterans Affairs Health Care Center''.

(2) REFERENCES.—Any reference in any law, regulation, map, document, paper, or other record of the United States to the medical center of the Department referred to in paragraph (1) shall be deemed to be a reference to the Treto Garza South Texas Department of Veterans Affairs Health Care Center.

(c) REQUIREMENT OF FULL-SERVICE INPATIENT FACILITY.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall ensure that the Treto Garza South Texas Department of Veterans Affairs Health Care Center, as designated under subsection (b), includes a full-service inpatient health care facility of the Department and shall modify the existing facility as necessary to meet that requirement.

(2) PLAN TO EXPAND FACILITY CAPABILITIES.—The Secretary shall include in the annual Strategic Capital Investment Plan of

the Department for fiscal year 2016 a project to expand the capabilities of the Treto Garza South Texas Department of Veterans Affairs Health Care Center, as so designated, by adding the following:

(A) Inpatient capability for 50 beds with appropriate administrative, clinical, diagnostic, and ancillary services needed for support.

(B) An urgent care center.

(C) The capability to provide a full range of services to meet the health care needs of women veterans.

(d) REPORT TO CONGRESS.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report detailing a plan to implement the requirements in subsection (c), including an estimate of the cost of required actions and the time necessary for the completion of those actions.

(e) SOUTH TEXAS DEFINED.—In this section, the term ''South Texas'' means the following counties in Texas: Aransas, Bee, Brooks, Calhoun, Cameron, DeWitt, Dimmit, Duval, Goliad, Hidalgo, Jackson, Jim Hogg, Jim Wells, Kenedy, Kleberg, Nueces, Refugio, San Patricio, Starr, Victoria, Webb, Willacy, Zapata.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 195—DESIGNATING THE ULYSSES S. GRANT ASSOCIATION AS THE ORGANIZATION TO IMPLEMENT THE BICENTENNIAL CELEBRATION OF THE BIRTH OF ULYSSES S. GRANT, CIVIL WAR GENERAL AND 2-TERM PRESIDENT OF THE UNITED STATES

Mr. BLUNT (for himself, Mrs. MCCASKILL, Mr. COCHRAN, Mr. WICKER, Mr. BROWN, Mr. PORTMAN, Mr. DURBIN, Mr. KIRK, Mr. SCHUMER, and Mrs. GILLIBRAND) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 195

Whereas Ulysses S. Grant was born in southern Ohio on April 27, 1822, to Jesse Grant and Hannah Simpson Grant;

Whereas the first line of the memoirs of Ulysses S. Grant proudly states: ''My Family is American, and has been for generations, in all its branches, direct and collateral.'';

Whereas Ulysses S. Grant attended school in Georgetown, Ohio, graduated from the United States Military Academy in 1843, and entered the United States Army;

Whereas Ulysses S. Grant served in a variety of military posts from the Atlantic Coast to the Pacific Coast, including posts in New York, Michigan, and California, and a post at the famous Jefferson Barracks in Missouri;

Whereas Ulysses S. Grant distinguished himself in combat during the Mexican-American War and worked tirelessly to succeed in civilian life;

Whereas, as a civilian farmer in Missouri, Ulysses S. Grant—

(1) met and married his wife, Julia Dent, for whom Ulysses S. Grant built a home named Hardscrabble;

(2) worked alongside slaves and emancipated the only slave that Ulysses S. Grant owned; and

(3) continued to own land while Ulysses S. Grant was President;

Whereas when the Civil War erupted, Ulysses S. Grant left Galena, Illinois to rejoin the United States Army, gained the colonelcy of the 21st Illinois Volunteer Regiment, and began his meteoric military rise;

Whereas during the Civil War, Ulysses S. Grant led troops in numerous victorious battles including—

(1) in Tennessee, at Forts Henry and Donelson and at Shiloh and Chattanooga; and

(2) in Mississippi, at Vicksburg;

Whereas President Abraham Lincoln chose Ulysses S. Grant to be Commanding General during the Civil War, and in that role Ulysses S. Grant revolutionized warfare in Virginia to preserve the Union;

Whereas in gratitude, the people of the United States twice elected Ulysses S. Grant President of the United States;

Whereas during his Presidency from 1869 to1877, Ulysses S. Grant worked valiantly to help former slaves become full citizens and became the first modern President of the United States;

Whereas after leaving the Presidency, Ulysses S. Grant became the first President of the United States to tour the world;

Whereas Ulysses S. Grant established a foreign policy that the United States followed into the 20th century and beyond;

Whereas Ulysses S. Grant authored his memoirs, the most significant piece of 19th-century nonfiction, while courageously battling cancer, which eventually took his voice and his life but did not silence the noble words that he left as a legacy;

Whereas the Ulysses S. Grant Association was founded during the Centennial of the Civil War in 1962 by the leading historians of that era and the Civil War Centennial Commissions of New York, Illinois, and Ohio, 3 States where Ulysses S. Grant lived;

Whereas, in the years since it was founded in 1962, the Ulysses S. Grant Association—

(1) has produced 32 volumes of ''The Papers of Ulysses S. Grant'', the major source for the study of the life of Ulysses S. Grant and the 19th century in which he lived; and

(2) has worked toward the publication of the first scholarly edition of the memoirs of Ulysses S. Grant, which as of May 2015, is nearing completion;

Whereas the Ulysses S. Grant Association was first headquartered at the Ohio Historical Society located on the campus of Ohio State University, later moved to Southern Illinois University, and relocated in 2008 to Mississippi State University; and

Whereas in 2012, the Ulysses S. Grant Association established the Ulysses S. Grant Presidential Library, the world center for Ulysses S. Grant scholars and tourists: Now, therefore, be it

Resolved, That the Senate—

(1) proclaims 2022 as the Bicentennial year for the celebration of the birth of Ulysses S. Grant, military leader and President;

(2) designates the Ulysses S. Grant Association, housed at the Ulysses S. Grant Presidential Library on the grounds of Mississippi State University, as the designated institution for organizing and leading the celebration of the bicentennial; and

(3) encourages the people of the United States to join in that bicentennial celebration to honor Ulysses S. Grant, 1 of the major historical figures of the United States.

SENATE RESOLUTION 196—DESIGNATING JULY 10, 2015, AS COLLECTOR CAR APPRECIATION DAY AND RECOGNIZING THAT THE COLLECTION AND RESTORATION OF HISTORIC AND CLASSIC CARS IS AN IMPORTANT PART OF PRESERVING THE TECHNOLOGICAL ACHIEVEMENTS AND CULTURAL HERITAGE OF THE UNITED STATES

Mr. BURR (for himself and Mr. TESTER) submitted the following resolution; which was considered and agreed to:

S. RES. 196

Whereas many people in the United States maintain classic automobiles as a pastime and do so with great passion and as a means of individual expression;

Whereas the Senate recognizes the effect that the more than 100-year history of the automobile has had on the economic progress of the United States and supports wholeheartedly all activities involved in the restoration and exhibition of classic automobiles;

Whereas the collection, restoration, and preservation of automobiles is an activity shared across generations and across all segments of society;

Whereas thousands of local car clubs and related businesses have been instrumental in preserving a historic part of the heritage of the United States by encouraging the restoration and exhibition of such vintage works of art;

Whereas automotive restoration provides well-paying, high-skilled jobs for people in all 50 States; and

Whereas automobiles have provided the inspiration for music, photography, cinema, fashion, and other artistic pursuits that have become part of the popular culture of the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates July 10, 2015, as ''Collector Car Appreciation Day'';

(2) recognizes that the collection and restoration of historic and classic cars is an important part of preserving the technological achievements and cultural heritage of the United States; and

(3) encourages the people of the United States to engage in events and commemorations of Collector Car Appreciation Day that create opportunities for collector car owners to educate young people about the importance of preserving the cultural heritage of the United States, including through the collection and restoration of collector cars.

SENATE RESOLUTION 197—RECOGNIZING THE NEED TO IMPROVE PHYSICAL ACCESS TO MANY FEDERALLY FUNDED FACILITIES FOR ALL PEOPLE OF THE UNITED STATES, PARTICULARLY PEOPLE WITH DISABILITIES

Mr. BLUMENTHAL (for himself, Ms. AYOTTE, Mr. MURPHY, Mr. MENENDEZ, Mr. BROWN, and Mr. SCHATZ) submitted the following resolution; which was considered and agreed to:

S. RES. 197

Whereas, in 2012, nearly 20 percent of the civilian population in the United States reported having a disability;

Whereas, in 2012, 16 percent of veterans, amounting to more than 3,500,000 people, received service-related disability benefits;